Maple Clinic

CONSENT TO AUTHORIZE DISCLOSURE OF MEDICAL INFORMATION

Pursuant to the Personal Health Information Act, 2004 (PHIPA), this form is for the purpose of authorizing someone other than yourself to communicate with our staff with regard to your medical information. (*See page 2 for details*).

1. **Patient providing Authorization (PLEASE COMPLETE IN FULL)**

Name – Last, First MI		☐ Patient is providing VERBAL CONSENT TO EWFHT (office use only)
Street Address (and mailing if different)		Telephone # (xxx) xxx-xxxx
City	Province	Postal Code
Date of Birth mm/dd/yyyy		Patient # (office use only)

2. **The person listed below is authorized to access my medical information**:

Name – Last, First MI		☐ Patient is providing VERBAL CONSENT TO EWFHT (office use only)
Street Address (and mailing if different)		Telephone # (xxx) xxx-xxxx
City	Province	Postal Code
Relationship with patient (ie: spouse, partner, father, mother, guardian, son, daughter, in-law, power of attorney, etc.)		

Additional person listed below is also authorized to access my medical information:

Name – Last, First MI		☐ Patient is providing VERBAL CONSENT TO EWFHT (office use only)
Street Address (and mailing if different)		Telephone # (xxx) xxx-xxxx
City	Province	Postal Code
Relationship with patient (ie: spouse, partner, father, mother, guardian, son, daughter, in-law, power of attorney, etc.)		

3. **INFORMATION TO BE RELEASED:**

☐ All Information (including telephone/verbal communication)
☐ ONLY for the following subject: ____________________
☐ ALL information EXCEPT the following subject: ____________________

4. This authorization will remain in effect until revoked by you in writing. If you wish to limit the duration of this authorization, please specify end date: ☐ ____________________

5. I authorize release of my medical information in accordance with the specifications listed above. I will receive/retain a copy of my signed authorization. Documented (signed or verbal) consent will be recorded in my medical chart. A photocopy of this consent shall be valid as the signed original.

Signature of Patient ____________________ Date ____________________

Witnessed/documented by: ____________________ (staff initials)

Ontario

ADDITIONAL INFORMATION REGARDING
CONSENT TO DISCLOSE PATIENT MEDICAL INFORMATION

Privacy regulations require your health care team to not divulge any information to unauthorized persons.

Family Members In today's world, it is common for a spouse or partner to arrange appointments for their family members, to check if they should come back for a follow-up, etc. However, it is not permissible for a spouse to act on their spouse's behalf unless authorized. For this, we require **written or documented verbal consent** to be on file.

Similarly, it is assume and permissible for a parent or legal guardian to coordinate and manage the health care needs for a child. **However, under PHIPA (Personal Health Information Protection Act, 2004) there is *no defined age of consent* in the province of Ontario.** Therefore, patients under 16 years of age who are capable of understanding the relevant information and the consequences pertaining to their own health care may, *at any time,* elect to designate an individual(s) to be authorized to access their health information. This **written or documented verbal consent** is required to be on file.

Patients 16 years of age or older are required to provide authorization to a parent or guardian or other designate of choice to access their medical information *should they choose to do so,* per the Health Care Consent Act, 1996. This also requires **written or documented verbal consent to be on file**.

Names, Residence, Custody
It becomes difficult to manage cases where spouses' surnames are different, the surnames of any of the parents are different from their children, family members reside at different residences, custody agreements are in place, etc. In these cases, full details must be provided in writing and kept on file.

Revocation
You have the right to revoke this authorization, in writing or verbally, at any time before it ends. However, your revocation will not affect any disclosures of your medical information that have already been made, in reliance of this authorization, before the time you revoke it. It may not be effective in certain circumstances where the insurer is contesting a claim. Verbal revocation will be documented by Maple staff. However, written revocation or any question
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should be addressed to:

Privacy Officer, Maple Clinic 1051 Markham Road, Scarborough, ON

Signatures
You are the only person who is permitted to sign a form to authorize the disclosure of your medical information. A spouse, parent or guardian cannot authorize disclosure of medical information for you unless they have legal rights to do so.

THIS FORM MUST BE SIGNED BY YOU, THE AUTHORIZING PATIENT, AT ONE OF OUR LOCATIONS BELOW, OR YOUR VERBAL CONSENT WILL BE DOCUMENTED BY OUR STAFF UPON YOUR EXPLICIT REQUEST. THIS SIGNED FORM OR DOCUMENTED VERBAL CONSENT WILL BE RECORDED IN YOUR MEDICAL RECORDS.

Fax no.- 877-366-4575
Email- contact@mapleclinic.info

Please fill the form and send to us

Ontario